

## CHAPTER 3

# People Served in Funded Service Settings

### OVERVIEW OF THE POPULATIONS SERVED

The Division of Mental Health and Addiction (DMHA) targets resources to adults with serious mental illness (SMI), children with serious emotional disturbance (SED), and persons of all ages with substance abuse (SA) disorders. Included within these groups, or “populations,” are “critical populations” that have historically encountered difficulty in accessing or maintaining services, such as minorities, persons with disabilities, and older adults. Resources for primary prevention services, however, target a universal population that is not in need of treatment. The purpose of prevention is to be proactive in delaying the onset of substance use and prevent illicit drug use. The general population is also targeted to prevent problem gambling.

The interests of these differing populations are represented in the DMHA through a system of advisory committees and specialized bureaus (see Appendix 2). Each bureau is led by a bureau chief and a 15 member advisory committee. The advisory committees meet quarterly and are composed of consumers, family members, advocates, and interested professionals. The bureaus advocate on behalf of their specific populations by gathering information, discussing issues, and developing recommendations to address identified needs.

The DMHA Mental Health Advisory Council (MHAC) meets monthly to advise the DMHA Director. The statutorily required, 10-member Council includes a representative from each bureau advisory committee and four at-large members. Each bureau meets with the MHAC annually to address issues specific to their population.

### INDIANA POPULATION AND THE PREVALENCE OF MENTAL ILLNESS

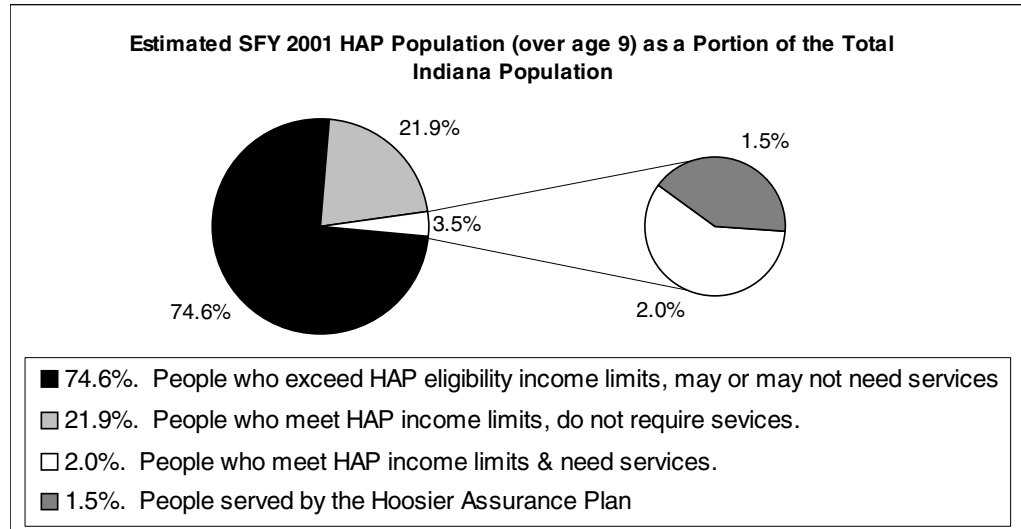
The same law that established the Hoosier Assurance Plan (HAP) also directed the DMHA to contract for a professionally designed actuarial study to quantify the populations to be targeted for public mental health services (Sect. 90). In 1997 the DMHA contracted with William M. Mercer, Inc., for an Actuarial Needs Assessment for SFY 1999 Provider Contracts. To establish the size of the HAP’s target population, Mercer’s Actuarial Study applied 1990 census income counts and 1993 census estimate of persons at or below 200% of the federal poverty level (FPL) to the 1995 census estimate of total population. Based on the results of this study, prevalence rates were established for the major population groups that the HAP is designed to serve.

The income criteria for the HAP states that individuals must have an income at or below 200% of the federal poverty level (FPL). The poverty threshold changes annually, and more information can be found on the U.S. Census Bureau website: [www.census.gov/](http://www.census.gov/) or on the U.S. Department of Health and Human Services (HHS) website: [aspe.hhs.gov/poverty/poverty.htm](http://aspe.hhs.gov/poverty/poverty.htm). According to the HHS website for the year 2001, a family of three was considered to be in poverty if the household income was \$14,630 or less, and to meet HAP income criteria, the income would be \$29,260 or less (twice the income of the federal poverty level, or 200% of the FPL).

Figure 3.1 illustrates the prevalence of mental illness in Indiana as it relates to Indiana citizens being served by the Hoosier Assurance Plan. There are an estimated 74.6% of Hoosiers who may or may not require mental health or addiction services who have an income too high to be eligible for HAP services.

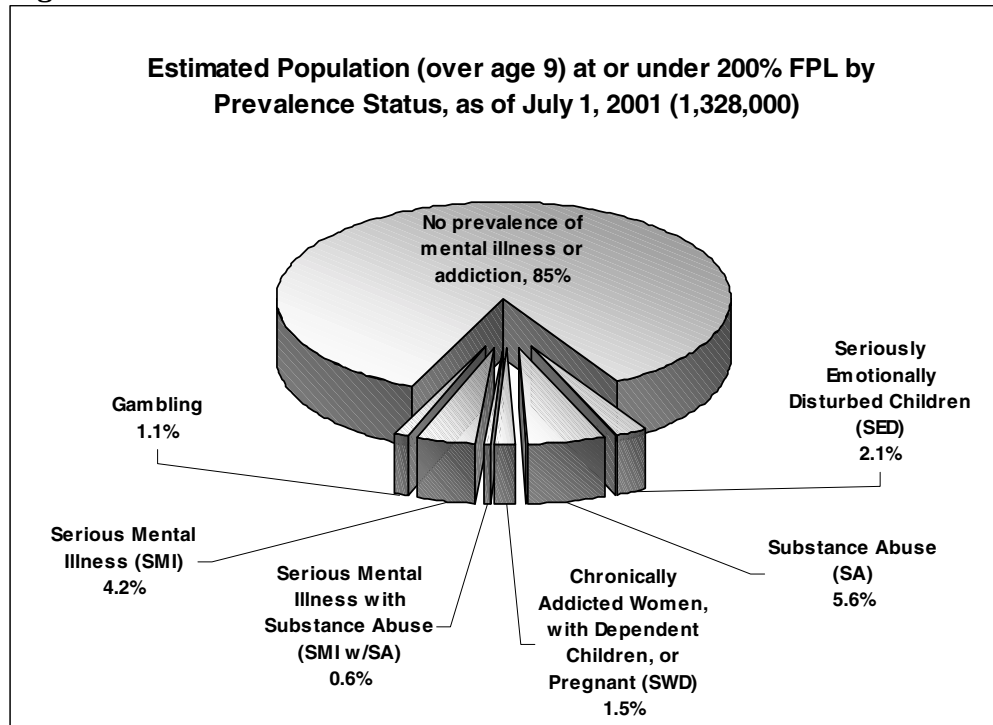
It is estimated that 21.9% of Hoosiers do fall within the HAP income eligibility limits, but do not require mental health or addiction services. Of all Hoosiers, 3.5% meet the HAP income criteria and require mental health or addiction services, and of those, 1.5% are served by the Hoosier Assurance Plan.

**Figure 3.1**



Sources: US Census Bureau; U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Administration, Center for Mental Health Services

**Figure 3.2**

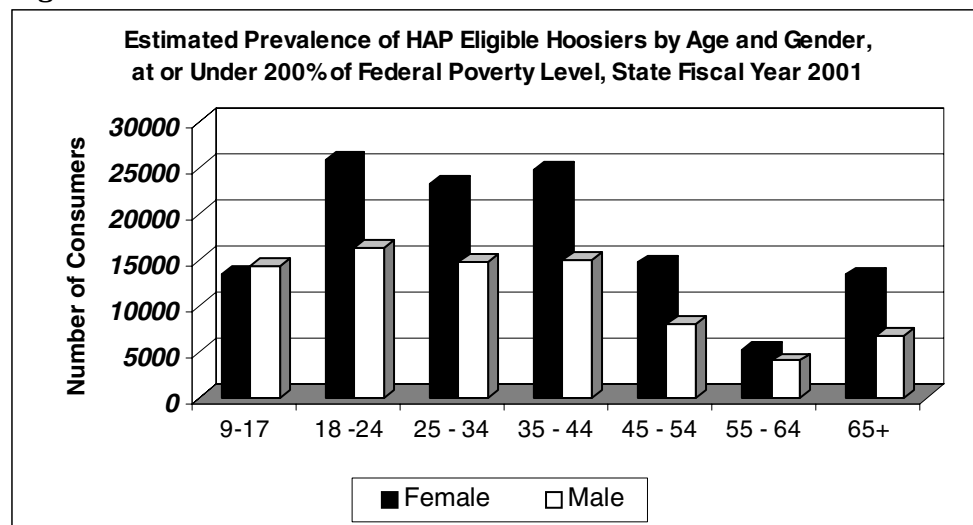


Sources: US Census Bureau; U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Administration, Center for Mental Health Services

Figure 3.2 shows Hoosiers who meet the HAP income eligibility criteria and who do or do not require mental health or addiction services. This entire pie chart represents the 3.5% and 21.9% of people shown in Figure 3.1. Of those that require services, it is estimated that 7.1% require services for substance abuse (SA and SWD), and 4.2% require services for serious mental illness (SMI).

Figure 3.3 shows the age and gender differences of Hoosiers who meet the HAP income eligibility criteria and who require mental health or addiction services. There are substantial gender differences across most age groups in the prevalence of mental illness and chronic addiction. The higher proportion of women in all adult age groups is due to a combination of factors. The two most prominent are the higher proportion of women with an annual income below 200% of the federal poverty level (FPL) and women's higher prevalence rates of serious mental illness.

**Figure 3.3**



Sources: US Census Bureau; U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Administration, Center for Mental Health Services

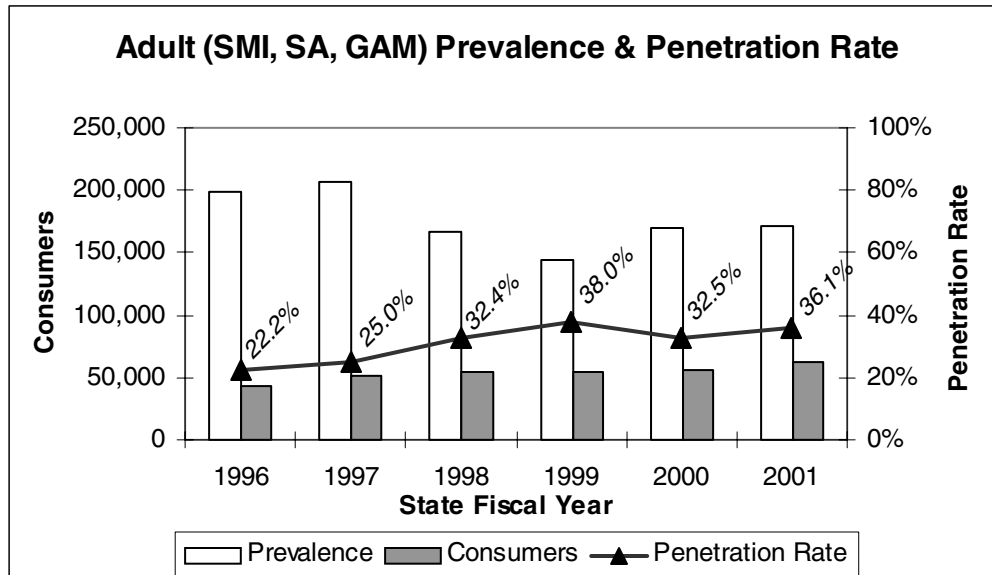
## THE PERCENT OF THE PREVALENT POPULATION SERVED BY HAP COMMUNITY SERVICES

Figure 3.4 shows the estimated numbers (prevalence estimates) of all adult Hoosiers with serious mental illness (SMI), substance abuse (SA), and gambling addiction (GAM) who meet HAP income and diagnostic criteria. Figure 3.4 also shows the number of those people who are served by the Hoosier Assurance Plan (with their corresponding percentage). These individuals were shown in Figure 3.1 as 3.5% of the total. In SFY 2001, it can be seen that 36.1% of those Hoosiers with estimated prevalence were being served by the Hoosier Assurance Plan. At least some of those eligible Hoosiers who are not receiving services through HAP are receiving services through Medicaid or from other sources. Fluctuations in the size of the prevalence populations are primarily due to varying year-to-year census poverty estimates. Since SFY 1996, generally decreasing poverty and steadily increasing HAP enrollment have combined to improve HAP penetration rates.

Figure 3.5 shows the prevalence estimates of Hoosier children (age 9 and over) with serious emotional disturbance (SED) and also shows the number of those children who are served by the HAP (with their corresponding percentage). In SFY 2001, it is shown that 51.3% of Hoosier children who meet the HAP income and mental health criteria were being served by the Hoosier Assurance Plan. Figure 2.2 (Chapter 2) shows there were 84,304 HAP consumers served in SFY 2001. This same estimate of consumers served shown in Figures 3.4 and 3.5 totals approximately 74,000. The difference is due to two factors,

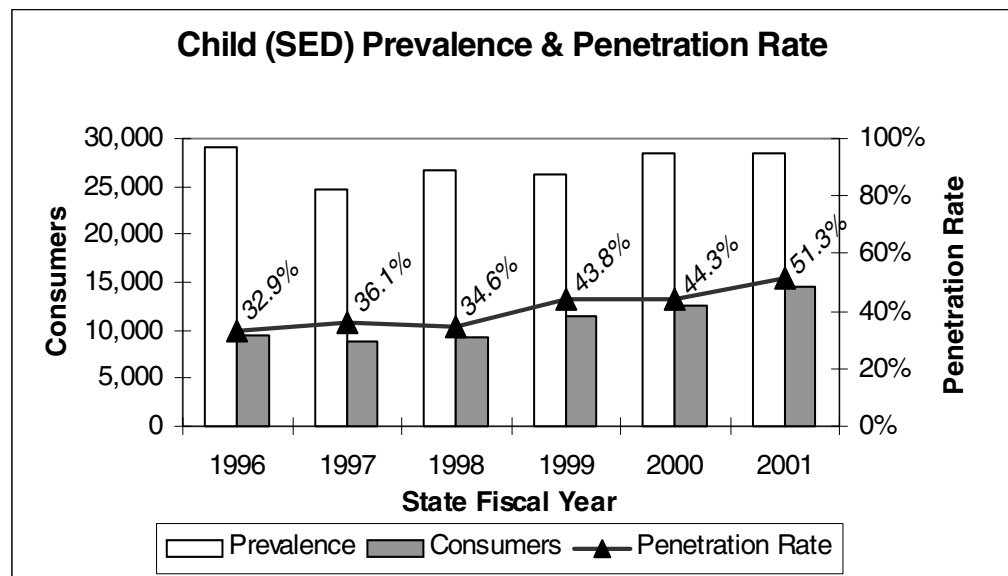
both related to standardized prevalence rates. There are no standardized prevalence rates for substance abuse (SA) among children under age 18, or for children with SED who are under age 9. To achieve an accurate calculation of penetration rate, counts of those consumers are not included in Figure 3.5.

**Figure 3.4**



Sources: DMHA MERR databases and Community Services Data System; US Census Bureau; U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Administration, Center for Mental Health Services

**Figure 3.5**



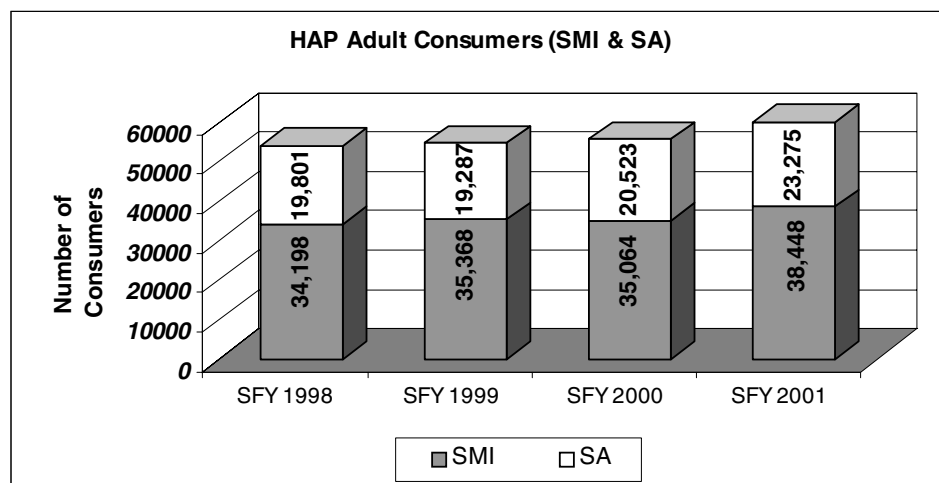
Sources: DMHA MERR databases and Community Services Data System; U.S. Census Bureau; U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Administration, Center for Mental Health Services

## CONSUMERS SERVED IN THE COMMUNITY

This section examines data on consumers of HAP services who are living in the community, first examining data for adult consumers, then looking at data for children. The next section explores data on people who are receiving state psychiatric hospital services.

Figure 3.6 shows the number of HAP adult consumers with serious mental illness (SMI) and substance abuse (SA) who were served by HAP over a four-year period. In SFY 2001, there were 61,723 adults served by HAP. The number of adult consumers has grown steadily over the four years shown, averaging 4.2% growth per year over the last three years.

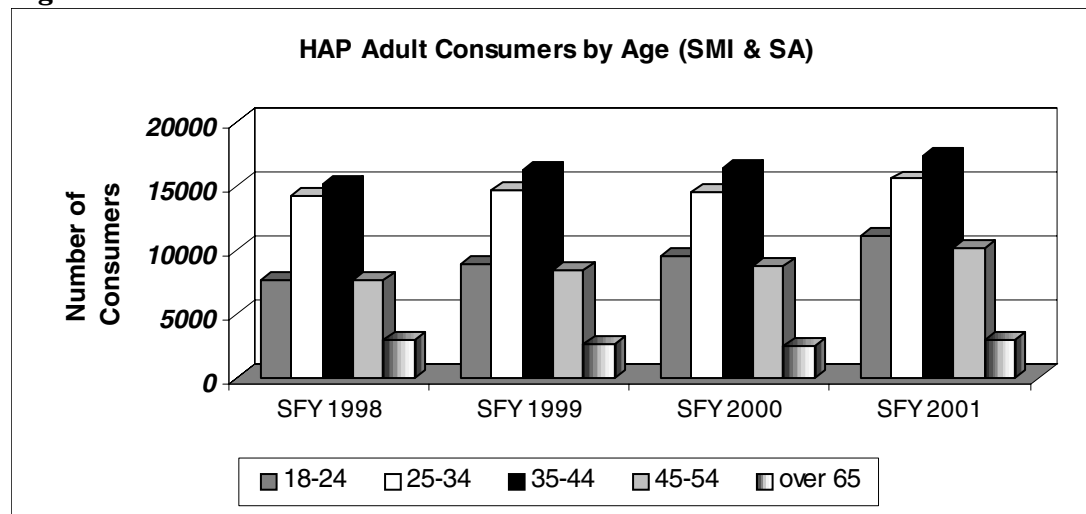
**Figure 3.6**



Source: DMHA MERR databases and Community Services Data System

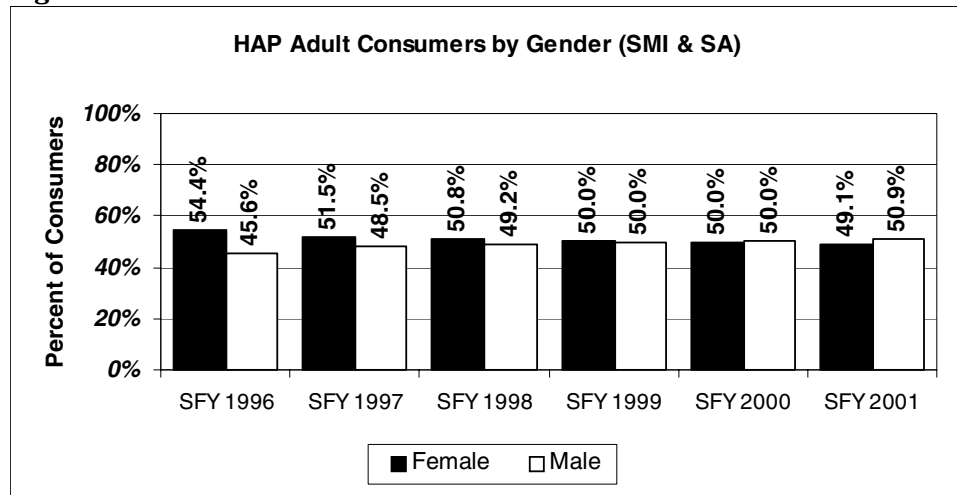
Figure 3.7 examines the number of HAP adult consumers (SMI and SA) served by different age groupings. While the HAP is consistently serving more consumers in the community, Figure 3.7 shows that the greatest increase in service from SFY 1998 to SFY 2001 is in the 18-24 age group. This is also the age group with the highest prevalence rates.

**Figure 3.7**



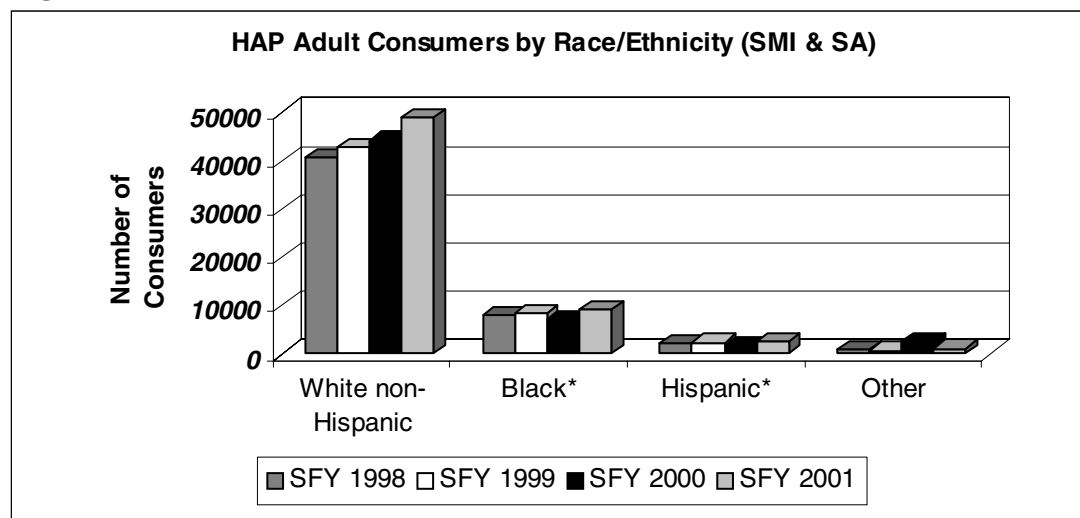
Source: DMHA MERR databases and Community Services Data System

Figure 3.8 shows the percent of females and the percent of males receiving services for serious mental illness (SMI) and substance abuse (SA), over a 6 year time period. While in SFY 1996 the percent of males and females being served were 45.6% and 54.4%, respectively, by SFY 2001 we see a trend toward equal numbers of males and females being served. It should be noted that in general women have higher SMI prevalence rates than men, while SA prevalence rates are more comparable. Yet, men with SA are more likely to be referred for treatment than women with SA.

**Figure 3.8**

Source: DMHA MERR databases and Community Services Data System

Figure 3.9 shows the number of HAP adult consumers (SMI and SA) by race and ethnicity. These numbers reflect the relatively low rate of minorities in the Indiana population and also show that the growth in HAP has included a growth in service to minorities. In order to provide quality service to all Hoosiers, the DMHA provides specialized training to HAP providers using the Cultural Competency Action Training Project, which is a series of Cultural Competence Training Sessions. The goal of this program has been to assist the managed care providers (MCPs) in developing an organizational infrastructure to address cultural competency in order to improve treatment outcomes for the various cultural groups within their service regions.

**Figure 3.9**

\*Includes 0.2% to 0.4% duplicate count of those reporting both black and Hispanic.

Source: DMHA MERR databases and Community Services Data System

Figure 3.10 shows the number of child and adolescent consumers, both seriously emotionally disturbed (SED) and substance abuse (SA), who were served by HAP over a four-year period. This number increases dramatically at an average rate of 13.6% per year over the last three years. The DMHA offers many services targeted to children and adolescents, two of which are described below.

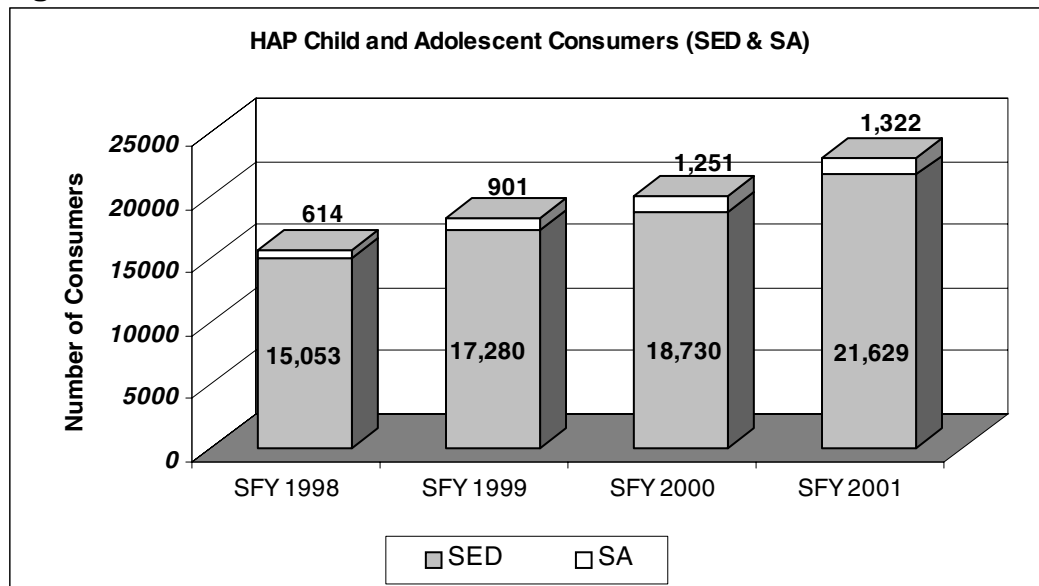
**System of Care Start-Up Funding:** This is a collaborative effort between the DMHA and the Division of Family Resources (DFR). Four local program sites were selected and began operation in July 2000. Project sites are required to develop a broad coalition of child serving entities, including parents, who are committed to the philosophy of the project. One area that must be addressed by applicants is a preliminary plan to blend state and local funds to support services for children with serious emotional disturbance (SED).

**The Dawn Project:** This is a community-based wraparound system of care program that began in 1996. The project's mission is to provide new and improved levels of assistance to children with SED and to their families.

*"If you haven't walked in our shoes you probably couldn't know the depth of despair we felt when we were losing our son to all the things that were challenging his health and well being. However, if you met us today you would surely see the hope and joy that we feel with a little more confidence each passing day. Though many professionals have helped us, and others tried to help, they were all handicapped by not using a strength-based child and family team. Dawn provides an intensive intervention that surrounds a family with services for a relatively short period of time. During that time things get turned around and put back together so the child and family can leave the Dawn Project in a position of strength and promise, with the support that they need in place."*

Excerpt from an essay by a Dawn Project parent

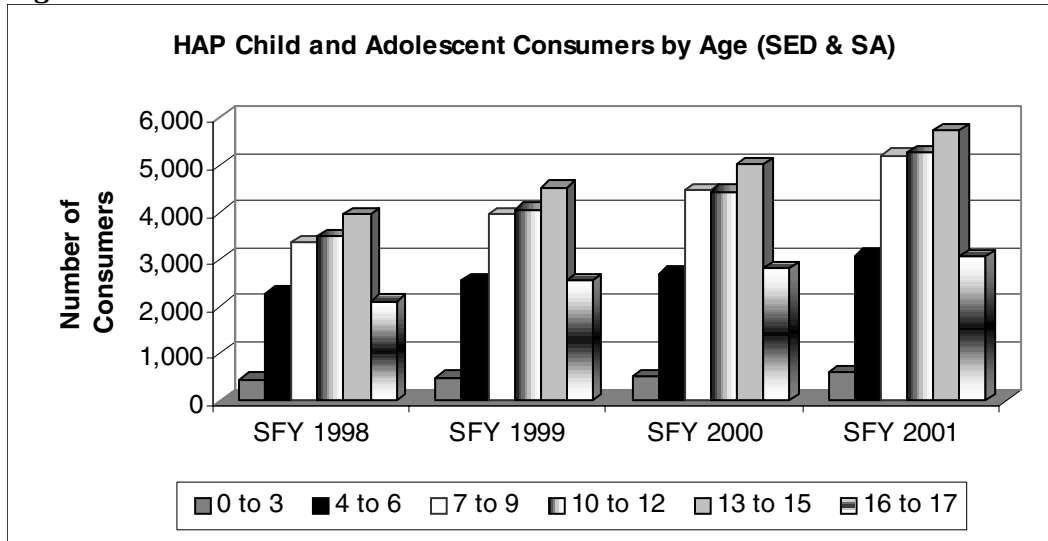
**Figure 3.10**



Source: DMHA MERR databases and Community Services Data System

Figure 3.11 shows the number of HAP child and adolescent consumers (SED and SA) served by age groupings. From the figure it appears that more children in certain age groups are receiving services, specifically ages 7-15.

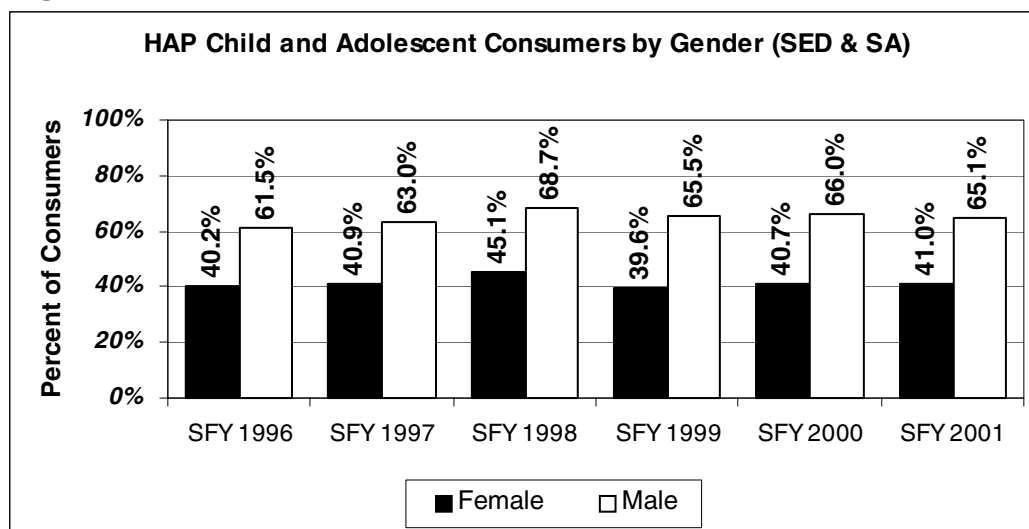
**Figure 3.11**



Source: DMHA MERR databases and Community Services Data System

Figure 3.12 examines HAP child and adolescent consumers (SED and SA), by gender across time. Similar to Figure 3.8 for adults, this figure shows the percent of females and males being served. There is a consistent trend for more males to be served than females. One explanation is that, as with adult substance abuse, even though prevalence rates are similar between males and females, males are more likely to exhibit types of behavior that get them referred for treatment.

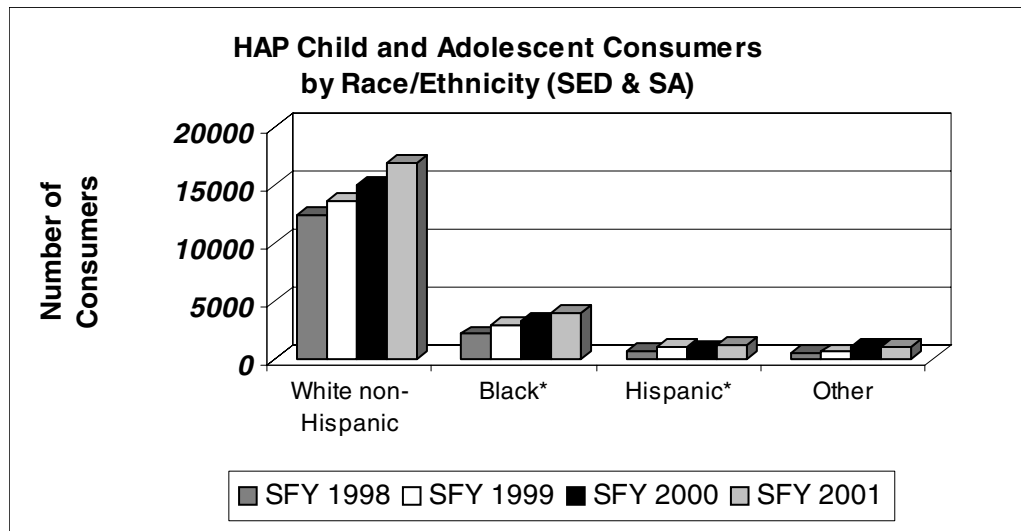
**Figure 3.12**



Source: DMHA MERR databases and Community Services Data System

Figure 3.13 shows HAP child and adolescent consumers (SED and SA) by race and ethnicity. Not unlike the same graph for adults, the HAP shows a growth in services to minorities.

**Figure 3.13**



Source: DMHA MERR databases and Community Services Data System

## STATE PSYCHIATRIC HOSPITAL PATIENTS

Figure 3.14 shows that the majority of patients in the state psychiatric hospitals continue to be adults in the 18-64 age grouping. The rate of ages 0-17 and 65+ has held fairly steady across the years shown.

**Figure 3.14\***

	SFY 1998	SFY 1999	SFY 2000	SFY 2001
Ages 0-17	103	107	100	93
Ages 18-64	1221	1198	1063	993
Ages 65+	90	101	88	82

\*Does not include Delta Services/Hamilton Center beds

Figure 3.15 shows the gender of patients in state psychiatric hospitals. Across the four years shown, there are significantly more male patients than female patients.

**Figure 3.15\***

	SFY 1998	SFY 1999	SFY 2000	SFY 2001
Male	989	963	759	853
Female	425	443	492	315

\*Does not include Delta Services/Hamilton Center beds